

Applicant : Jacob Bar-Tana
Serial No. : 10/735,439
Filed : December 11, 2003

Page 2 of 3: Communication in Response to November 28, 2008 Notice

REMARKS

In the November 28, 20008 Notice, a copy of which is attached hereto as **Exhibit A**, it was stated that the publications contained within "Exhibit G" and "Exhibit I" of the Amendment filed on August 28, 2008 (actually filed August 25, 2008), were unclear and illegible.

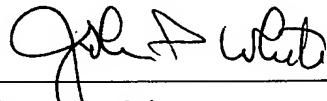
In response, applicant submits as **Exhibit B** and **Exhibit C** attached hereto replacement copies of the publications contained within "Exhibit G" and "Exhibit I" of the Amendment filed on August 25, 2008 respectively.

If a telephone interview would be of assistance in advancing prosecution of the subject application, the undersigned attorney invites the Examiner to telephone him at the telephone number provided below.

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Page 3 of 3: Communication in Response to November 28, 2008 Notice

No fee, other than the enclosed \$245.00 fee for a two-month extension of time is deemed necessary in connection with the filing of this Communication. However, if any additional fee is required, authorization is hereby given to charge the amount of any such fee to Deposit Account No. 03-3125.

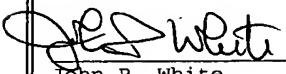
Respectfully submitted,



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I hereby certify that this correspondence is being deposited on this date with the U.S. Postal Service with sufficient postage as first class mail in an envelope addressed to:

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EXHIBIT A

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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR / PATENT IN REEXAMINATION	ATTORNEY DOCKET NO.
10/735,439	12/11/2003	BAR-TANA, JACOB	1567/70937-ZA /JPW/AG

John P. White
Cooper & Dunham LLP
1185 Avenue of the Americas
New York, NY 10036

Reply Due: 12/28/08

EXAMINER

Leslie A. Royds

ART UNIT	PAPER
1614	20081121

DATE MAILED:

Please find below and/or attached an Office communication concerning this application or proceeding.

Commissioner for Patents

NOTICE OF NON-RESPONSIVE AMENDMENT

Applicant's amendment and remarks filed August 28, 2008 have each been received and entered into the present application.

Consideration of the remarks and documents contained therein has been performed herein by the Examiner. It is noted that Applicant discusses and relies upon the content designated as "Exhibit G" and "Exhibit I" to establish and support Applicant's position that the instant claims circumscribe patentable subject matter over the cited prior art. However, it is noted on the record that each of these publications upon which Applicant relies is sufficiently unclear to preclude a full and complete consideration of the information contained therein to support Applicant's position that the claimed subject matter distinguishes over the prior art cited under 35 USC 103(a).

Accordingly, by issuance of this notice, Applicant is requested (and afforded the opportunity) to provide a full, clear and legible copy of the publications contained within "Exhibit G" and "Exhibit I" as relied upon in the Remarks for consideration by the Examiner of record in order to fully and properly consider the persuasiveness of Applicant's remarks regarding the rejections of record.

Since the above-mentioned response appears to be a bona fide attempt to reply, Applicant is given a TIME PERIOD of ONE (1), MONTH or THIRTY (30) DAYS, whichever is longer, from the mailing date of this notice within which to supply the omission or correction, in order to avoid abandonment. Extensions of this time period under 37 C.F.R. 1.136(a) are available.

Any inquiry concerning this communication or earlier communications from the Examiner should be directed to Leslie A. Royds, whose telephone number is (571)-272-6096. The Examiner can normally be reached from Monday through Friday, 9:00 AM to 5:30 PM. If attempts to reach the Examiner are unsuccessful, the Examiner's supervisor, Ardin H. Marschel, can be reached on (571)-272-6818. The fax phone number for the organization where this application or proceeding is assigned is (571)-273-8300.

/Ardin Marschel/
Supervisory Patent Examiner, Art Unit 1614

/Leslie A. Royds/
Patent Examiner, Art Unit 1614



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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR	ATTORNEY DOCKET NO.	CONFIRMATION NO.
10/735,439	12/11/2003	Jacob Bar-Tana	1567/70937-ZA /JPW/AG	2054
7590	11/28/2008		EXAMINER	
John P. White Cooper & Dunham LLP 1185 Avenue of the Americas New York, NY 10036			ROYDS, LESLIE A	
			ART UNIT	PAPER NUMBER
			1614	
			MAIL DATE	DELIVERY MODE
			11/28/2008	PAPER

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The time period for reply, if any, is set in the attached communication.

EXHIBIT B

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Applicant: Jacob Bar-Tana
Serial No.: 10/735,439
Filed : December 11, 2003
Exhibit B

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Library of Congress Catalog Card Number 1-31760

ISBN 0911910-10-7

ISSN 0076-6526

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TABLE 206-2. NORMAL LABORATORY VALUES (Continued)

Test	Specimen	Method	Normal Range	
			Conventional Units	SI Units
Bilirubin Direct Indirect	Serum Serum	Colorimetry Colorimetry Calculation: Total bilirubin minus direct bilirubin	≤ 0.4 mg/dL ≤ 1.3 mg/dL	≤ 7 μmol/L ≤ 22 μmol/L
Total Bleeding time, template CA 16-3	Serum Not appli- cable	Colorimetry Template method	≤ 1.3 mg/dL 2.5–9.5 min	≤ 22 μmol/L
CA 19-9*	Serum	ICG-MEIA IRMA	< 33 U/mL	< 32 KU/L
CA 27-29	Serum	BIOMIRA TRIQUANT BR RIA	< 38 U/mL	< 38 KU/L
CA 125	Serum	CENTOCOR CA 125 II RIA	< 35 U/mL	< 35 KU/L
Cadmium	Blood	Atomic spectroscopy	≤ 2 μg/L (nonnmol/L)	≤ 17.8 nmol/L (nonnmol/L)
Calprotectin	Serum	Immunoassay	Male: < 13.4 pg/mL Female: < 6.4 pg/mL	Male: < 13.8 ng/L Female: < 6.4 ng/L
Calcdium	Serum Urine	Colorimetry Colorimetry	8.5–10.3 mg/dL Male: < 300 mg/day Female: < 260 mg/day	2.12–2.57 mmol/L Male: < 7.5 nmol/day Female: < 6.2 nmol/day
Carbon dioxide	Serum	Colorimetry	20–32 mmol/L	20–32 mmol/L
Carboxyhemoglo- bin	Blood	Spectrophotom- etry	< 2% of total Hb (nonnmol/L)	< 0.02
Cardioieno- bryonic antigen (C14)	Serum	CHIRON ACS:180 ICMA	< 2.5 ng/mL (nonnmol/L)	< 2.5 μg/L (nonnmol/L)
Carotene	Serum	Colorimetry	60–300 μg/dL	0.9–6.6 μmol/L
Chloride	Plasma	HPLC	Dopamine Sapine: < 90 pg/mL Standing: < 90 pg/mL	Dopamine Sapine: < 688 pmol/L Standing: < 688 pmol/L
Cholesterol Fractionated	Plasma	HPLC	Epinephrine Sapine: < 50 pg/mL Standing: < 90 pg/mL	Epinephrine Sapine: < 273 pmol/L Standing: < 491 pmol/L
Total	Plasma	HPLC	Norepinephrine Sapine: 110–410 pg/mL Standing: 125–700 pg/mL	Norepinephrine Sapine: 650–2423 pmol/L Standing: 739–4137 pmol/L
Ceruloplasmin	Serum	Nephelometry	Sapine: 120–460 pg/mL Standing: 160–750 pg/mL	Sapine: 709–2690 pmol/L Standing: 887–4453 pmol/L
Chloride	Serum	ISE	25–63 mg/dL	250–630 mg/L
Cholesterol, total	Serum	Colorimetry	85–108 mmol/L	85–108 nmol/L
Complement	Serum	Nephelometry	Dedirable: < 200 mg/dL	Desirable: < 6.17 mmol/L
C3	Serum	Nephelometry	Borderline-high: 200–239 mg/dL	Borderline-high: 6.17–6.18 mmol/L
C4	Serum	Nephelometry	High: ≥ 240 mg/dL	High: ≥ 6.21 nmol/L
Total (CH ₅₀)	Serum	Liposome lysis	75–161 mg/dL	0.76–1.61 g/L
Complete blood count (CBC)	Blood	Automated hematology analyzer	16–47 mg/dL 31–66 U/mL	0.16–0.47 g/L 31–66 KU/L

CA 16-9	Serum	ABBOTT AXSYM CA 15-3 MEIA	< 32 U/mL	
CA 19-9*	Serum	CIS ELSA-CA 19-9 IRMA	< 33 U/mL	< 33 kU/L
CA 27.29	Serum	BIMMIRA TRIQUANT BR RIA	< 38 U/mL	< 38 kU/L
CA 125	Serum	CENTOCOR CA 125 II RIA	< 35 U/mL	< 35 kU/L
Cadmium	Blood	Atomic spectroscopy, ≤ 2 μ g/L (nonsmoker)	≤ 17.8 μ mol/L (nonsmoker)	
Calcitonin	Serum	Immunassay	Male: < 13.8 ng/mL Female: < 6.4 ng/mL	Male: < 13.8 ng/L Female: < 6.4 ng/L
Calcium	Serum	Colorimetry Colorimetry	8.5–10.3 mg/dL Male: < 300 mg/day Female: < 250 mg/day	2.12–2.57 mmol/L Male: < 7.5 mmol/day Female: < 6.2 mmol/day
Carbon dioxide	Serum	Colorimetry Spectrophotometry	20–32 mmol/L < 2% of total Hb (nonsmoker)	20–32 mmol/L < 0.02
Carboxyhemoglobin	Blood	CHIRON ACS:180 ICMA	< 2.5 ng/mL (nonsmoker)	< 2.5 μ g/L (nonsmoker)
Carcinoembryonic antigen (CEA)	Serum	Colorimetry	50–300 μ g/dL	0.9–5.6 μ mol/L
Carotene	Plasma	HPLC	Dopamine	Dopamine
Carcinoembryonic Fractionated			Serpine: < 90 pg/mL Standing: < 80 pg/mL	Serpine: < 688 pmol/L Standing: < 688 pmol/L
Total	Plasma	HPLC	Epinephrine	Epinephrine
Ceruloplasmin	Serum	Nephelometry	Serpine: < 50 pg/mL Standing: < 50 pg/mL	Serpine: < 273 pmol/L Standing: < 273 pmol/L
Chloride	Serum	ISE	Norepinephrine	Norepinephrine
Cholesterol, total	Serum	Colorimetry	Serpine: 110–410 pg/mL Standing: 120–700 pg/mL	Serpine: 650–2423 pmol/L Standing: 739–4137 pmol/L
Complement	Serum	Nephelometry	Serpine: 120–450 pg/mL Standing: 150–750 pg/mL	Serpine: 768–2860 pmol/L Standing: 887–4438 pmol/L
C3	Serum	Nephelometry	25–63 mg/dL	250–630 mg/L
C4	Serum	Nephelometry	95–108 nmol/L	95–108 nmol/L
Total (CH ₃ o)	Serum	Liposome lysin	Desirable: < 200 mg/dL	Desirable: < 5.17 mmol/L
Complete blood count (CBC)	Blood	Automated hematology analyzer	Borderline-high: 200–238 mg/dL High: ≥ 240 mg/dL	Borderline-high: 6.17–6.18 mmol/L High: ≥ 6.21 mmol/L
Hemoglobin (Hb)				
Hematocrit (Hct)				
RBC count				
RBC Indices				
WBC count				
WBC differential				

Table continues on the following page.

TABLE 296-2. NORMAL LABORATORY VALUES (Continued)

Test	Specimen	Method	Normal Range	
			Conventional Units	SI Units
Human chorionic gonadotropin (hCG) Qualitative	Urine	Immunoassay	Nonpregnant: negative Pregnant: positive	Male: < 2 IU/L Female: Premenopausal: < 6 IU/L Postmenopausal: < 10 IU/L Pregnancy: 0-2 wk: < 500 IU/L 2-3 wk: 100-5,000 IU/L 3-4 wk: 500-10,000 IU/L 1-2 mo: 1,000-200,000 IU/L 2-3 mo: 10,000-100,000 IU/L
Quantitative (intact and free β)	Serum	Immunoassay	Male: < 2 IU/L Female: Premenopausal: < 6 IU/L Postmenopausal: < 10 IU/L Pregnancy: 0-2 wk: < 500 IU/L 2-3 wk: 100-5,000 IU/L 3-4 wk: 500-10,000 IU/L 1-2 mo: 1,000-200,000 IU/L 2-3 mo: 10,000-100,000 IU/L	Male: < 2 IU/L Female: Premenopausal: < 6 IU/L Postmenopausal: < 10 IU/L Pregnancy: 0-2 wk: < 500 IU/L 2-3 wk: 100-5,000 IU/L 3-4 wk: 500-10,000 IU/L 1-2 mo: 1,000-200,000 IU/L 2-3 mo: 10,000-100,000 IU/L
17-Hydroxycorticosteroids	Urine	Erythrocyte countmetry	Male: 3-16 µg/day Female: 2-12 µg/day 0.6-8.0 mg/day	Male: 8.3-41.4 µmol/day Female: 5.6-33.1 µmol/day 3-47 µmol/day
5-Hydroxyindole-acetic acid (5-HIAA)	Urine	HPLC		
Immunoglobulin IgA	Serum	Nephelometry	81-463 mg/dL ≤ 14 mg/dL	0.81-4.63 g/L ≤ 0.14 g/dL
IgD	Serum	Radial immunodiffusion		
IgE	Serum	Immunoassay	< 180 U/mL	< 432 µg/L
IgG, subclasses	Serum	Nephelometry	Subclass IgG 1: 450-900 mg/dL Subclass IgG 2: 180-530 mg/dL Subclass IgG 3: 13-80 mg/dL Subclass IgG 4: 8-100 mg/dL 723-1,686 mg/dL 48-271 mg/dL 5-26 µU/mL 25-170 µg/dL	Subclass IgG 1: 4.5-9.0 g/L Subclass IgG 2: 1.8-5.3 g/L Subclass IgG 3: 0.13-0.50 g/L Subclass IgG 4: 0.08-1.00 g/L 7.23-16.86 g/L 0.48-2.71 g/L 38-170 µmol/L 4-30 µmol/L
IgG, total	Serum	Nephelometry		
IgM	Serum	Nephelometry		
Insulin	Serum	Immunoassay		
Iron	Serum	Colorimetry		
Iron-binding capacity	Serum	Colorimetry Calculation: % transferrin saturation = (100 × total iron)/total iron-binding capacity	200-450 µg/dL % Saturation: 12-67%	38-81 µmol/L % Saturation: 0.12-0.67
17-Ketogenic steroids	Urine	Colorimetry	Male: 6-23 mg/day Female: 3-15 mg/day	Male: 17-80 µmol/day Female: 10-52 µmol/day
17-Ketosteroids, total	Urine	Colorimetry	Male: 9-22 mg/day Female: 6-16 mg/day	Male: 31-76 µmol/day Female: 17-52 µmol/day
Lactate dehydrogenase (LD) Isoenzymes	Serum	Electrophoresis	LD1: 20-36% of total LD2: 32-50% of total LD3: 16-25% of total LD4: 2-10% of total LD5: 3-13% of total ≤ 270 U/L	LD1: 0.20-0.36 of total LD2: 0.32-0.50 of total LD3: 0.16-0.25 of total LD4: 0.02-0.10 of total LD5: 0.03-0.13 of total ≤ 4.5 µkat/L
Total	Serum	Enzymatic colorimetry	9-16 mg/dL	1.0-1.4 µmol/L
Lactic acid	Plasma (venous)	Enzymatic colorimetry		
Lead	Blood	Atomic spectrometry	< 25 µg/dL	< 1.21 µmol/L
Uriase	Serum	Enzymatic	7-60 U/L	0.12-1.00 µkat/L

2-3 wk	100-5,000 IU/L	2-3 wk	100-5,000 IU/L	
3-4 wk	500-10,000 IU/L	3-4 wk	600-10,000 IU/L	
1-2 mo	1,000-200,000 IU/L	1-2 mo	1,000-200,000 IU/L	
2-3 mo	10,000-100,000 IU/L	2-3 mo	10,000-100,000 IU/L	
17-Hydroxy cortico-steroids	Urine Enzymatic colorimetry HPLC	Male: Female:	3-16 ng/day 2-12 ng/day	
6-Hydroxyindole-acetic acid (6-HIAA)	Urine Immunoglobulin IgA IgD	Serum Radial immunodiffusion Immunosassay Nephelometry	0.5-9.0 mg/day 0.5-47 μ mol/day	
IgG, total IgM IgE, subclasses	Urine Serum Serum Serum	Nephelometry Immunodiffusion Nephelometry Nephelometry	< 180 U/mL ≤ 14 mg/dL	
Insulin	Urine Serum	Subclass IgG 1: 450-900 mg/dL Subclass IgG 2: 180-630 mg/dL Subclass IgG 3: 13-80 mg/dL Subclass IgG 4: 8-100 mg/dL	< 432 μ g/L Subclass IgG 1: 4.6-9.0 g/L Subclass IgG 2: 1.8-5.3 g/L Subclass IgG 3: 0.13-0.80 g/L Subclass IgG 4: 0.08-1.00 g/L	
Iron	Urine Serum Serum Serum	723-1885 mg/dL 48-271 mg/dL 6-25 μ U/mL 25-170 μ g/dL	7.23-16.86 g/L 0.48-2.71 g/L 36-178 pmol/L 4-30 μ mol/L	
Iron-binding capacity	Serum	Colorimetry Calculation: % transferrin saturation = $(100 \times \text{total iron}) / (\text{total iron} + \text{iron-binding capacity})$	200-450 μ g/dL % Saturation: 12-57%	
17-Ketogenic steroids	Urine	Colorimetry	Male: 6-23 μ g/day Female: 3-16 μ g/day	
17-Ketosteroids, total	Urine	Colorimetry	Male: 9-22 μ g/day Female: 6-16 μ g/day	
Lactate dehydrogenase (LD) isoenzymes	Serum	Electrophoresis	LD1: 20-36% of total LD2: 32-50% of total LD3: 15-25% of total LD4: 2-10% of total LD5: 3-13% of total ≤ 270 U/L	
Total	Serum	Enzymatic colorimetry	LD1: 20-36% of total LD2: 32-50% of total LD3: 15-25% of total LD4: 2-10% of total LD5: 3-13% of total ≤ 4.6 μ kat/L	
Lactic acid	Plasma (venous)	Enzymatic colorimetry	9-16 mg/dL	
Lead	Blood	Auric spectrometry	1.0-1.8 μ mol/L	
Lipase	Serum	Enzymatic colorimetry	< 121 μ kat/L 0.12-1.00 μ kat/L	
Low density lipoprotein (LDL) cholesterol, direct	Serum	Immunoseparation/colorimetry	Desirable: < 130 mg/dL Borderline-high: 130-150 mg/dL High: ≥ 160 mg/dL	
Luteinizing hormone (LH)	Serum	Immunoassay	Male: 20-70 yr: 1.3-12.9 IU/L > 70 yr: 11.3-56.4 IU/L Female: Follicular phase Midcycle Luteal phase Pregnancy Postmenopausal	Female: Follicular phase: 0.8-25.8 IU/L Midcycle: 26.0-57.3 IU/L Luteal phase: 0.8-27.1 IU/L Pregnancy: < 1.4 IU/L Postmenopausal: 6.0-52.3 IU/L

Table continues on the following page.

EXHIBIT C

Brief Reports

Nicotinic Acid as Therapy for Dyslipidemia in Non-Insulin-Dependent Diabetes Mellitus

Abhimanyu Garg, MBBS, MD, Scott M. Grundy, MD, PhD

Recently, nicotinic acid has been recommended as a first-line hypolipidemic drug. To determine the effectiveness of nicotinic acid in dyslipidemic patients with non-insulin-dependent diabetes mellitus, 13 patients were treated in a randomized crossover trial. Patients received either nicotinic acid (1.5 g three times daily) or no therapy (control period) for 8 weeks each. Compared with the control period, nicotinic acid therapy reduced the plasma total cholesterol level by 24%, plasma triglyceride level by 45%, very-low-density lipoprotein cholesterol level by 58%, and low-density lipoprotein cholesterol level by 15%, and it increased the high-density lipoprotein cholesterol level by 34%. However, nicotinic acid therapy resulted in the deterioration of glycemic control, as evidenced by a 16% increase in mean plasma glucose concentrations, a 21% increase in glycosylated hemoglobin levels, and the induction of marked glycosuria in some patients. Furthermore, a consistent increase in plasma uric acid levels was observed. Therefore, despite improvement in lipid and lipoprotein concentrations, because of worsening hyperglycemia and the development of hyperuricemia, nicotinic acid must be used with caution in patients with non-insulin-dependent diabetes mellitus with dyslipidemia. We suggest that the drug not be used as a first-line hypolipidemic drug in patients with non-insulin-dependent diabetes mellitus.

(JAMA 1990;264:723-726)

DYSЛИPIDEMLA is a common finding in non-insulin-dependent diabetes mellitus (NIDDM)¹ and probably contributes causally to coronary heart disease, a major cause of death in patients with NIDDM.² Recently, the National Cholesterol Education Program proposed new guidelines for the management of high blood cholesterol levels.³ The guidelines obviously could not consider in depth every subgroup of patients with hyperlipidemias, and, therefore, problems of management of lipid and lipoprotein abnormalities in patients with NIDDM were not addressed in detail. The National Cholesterol Education Program recommended nicotinic acid and bile acid binding resins as first-line drugs for treatment of hypercholesterolemia, and nicotinic acid was designated as the drug of choice for hy-

PATIENTS AND METHODS

Patients

Thirteen male patients with NIDDM from a lipid clinic and a diabetes clinic were studied at the Veterans Administration Medical Center, Dallas, Tex. All patients had an insidious onset of diabetes after age 38 years, and none had a history of ketosis. Their ages ranged from 49 to 68 years (mean \pm SEM, 59 \pm 1 years). Body weights and body-mass indexes averaged 91.7 \pm 3.3 kg and

29.9 \pm 0.7 kg/m², respectively. Four patients were receiving glyburide therapy, eight patients were receiving a combination of isophane insulin suspension and regular human insulin (Squibb-Novo, Princeton, NJ) subcutaneously before breakfast and supper for glycemic control, and one patient was receiving dietary therapy only. C-peptide levels were determined for patients receiving insulin therapy, both in the fasting state and 90 minutes after they ingested 480 mL of Sustacal (Mead Johnson & Co, Evansville, Ind); average values were 751 \pm 182 and 1388 \pm 192 pmol/L, respectively, confirming the diagnosis of NIDDM.⁴ At entry, all patients had a plasma cholesterol level of 5.2 mmol/L or greater and/or a plasma triglyceride level of 2.8 mmol/L or greater. Six patients had coronary heart disease but none had recent myocardial infarction, unstable angina pectoris, or congestive heart failure. Patients were excluded if they had a history of peptic ulcer or gout, evidence of hyperuricemia (plasma uric acid concentration $>$ 475 μ mol/L), or abnormal test results for liver, kidney, or thyroid gland functions. For patients taking specific hypolipidemic drugs, such therapy was discontinued at least 2 months prior to the study.

Experimental Design

The study protocol was approved by the institutional review board, and each patient gave informed consent. All patients were studied during three hospitalizations in the metabolic ward, each lasting 5 days. Before being randomized, patients were hospitalized for 5 days, called the baseline period, during which the dosage of insulin or glyburide was adjusted to achieve good glycemic control, and energy intake was determined to project a constant body weight. Thereafter, no changes in the dosage of insulin or glyburide were allowed except to prevent symptomatic hypoglycemia. The plasma glucose con-

From the Veterans Administration Medical Center, Dallas (Drs Garg and Grundy), and the Center for Human Nutrition (Drs Garg and Grundy) and the Department of Clinical Nutrition (Drs Garg and Grundy), Internal Medicine (Drs Garg and Grundy), and Biochemistry (Dr Grundy), University of Texas Southwestern Medical Center at Dallas.

Reprint requests to Center for Human Nutrition, 5323 Harry Hines Blvd, Dallas, TX 75235-9052 (Dr Grundy).

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From the Veterans Administration Medical Center, Dallas (Drs Garg and Grundy), and the Center for Human Nutrition (Drs Garg and Grundy) and the Department of Clinical Nutrition (Drs Garg and Grundy), Internal Medicine (Drs Garg and Grundy), and Biochemistry (Dr Grundy), University of Texas Southwestern Medical Center at Dallas.

Reprint requests to Center for Human Nutrition, 5323 Harry Hines Blvd, Dallas, TX 75235-9052 (Dr Grundy).

Jyv et al

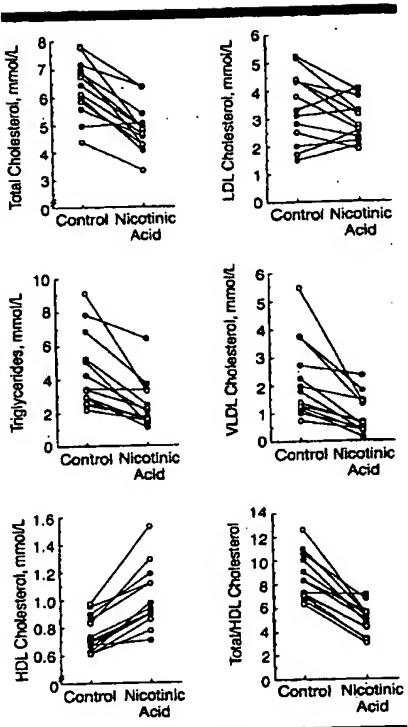


Fig 1.—Plasma levels of total cholesterol, low-density lipoprotein (LDL) cholesterol, triglycerides, very-low-density lipoprotein (VLDL) cholesterol, and high-density lipoprotein (HDL) cholesterol and the ratio of total to HDL cholesterol during the control and the nicotinic acid periods in 13 patients with non-insulin-dependent diabetes mellitus with dyslipidemia. Each circle represents the mean of five daily determinations. Solid circles indicate mean values in patients receiving insulin therapy; open circles, values in patients receiving glyburide therapy or diet alone.

centration was measured at 3, 7, and 11 AM and 4 and 9 PM each day. Fasting blood samples were drawn daily for analysis of lipids and lipoproteins. Blood was also drawn for a glycosylated hemoglobin determination and a routine hematologic and chemistry profile, including the uric acid concentration. Patients were instructed to follow an isocaloric diet throughout the study, the diet containing 50% carbohydrates, 30% fat, and 20% protein, with 300 mg of cholesterol.⁶ They were instructed not to consume alcohol during the trial.

After the baseline hospitalization, patients were randomized to receive nicotinic acid or no therapy for a period of 8 weeks. All patients then crossed over to the drug/no therapy (control) period for the next 8 weeks. A double-blind, placebo-controlled trial was not planned because of previous reports of the ineffective nature of this design due to symptomatic side effects of nicotinic acid therapy.⁶ The nicotinic acid dosage

Table 1.—Effect of Nicotinic Acid Therapy on Plasma Lipid and Lipoprotein Levels*

	Study Period			P†
	Baseline	Control	Nicotinic Acid	
Plasma cholesterol, mmol/L	6.71 ± 0.33	6.35 ± 0.28	4.82 ± 0.29	.0001
Plasma triglycerides, mmol/L	5.08 ± 0.64	4.48 ± 0.62	2.45 ± 0.40	.0008
VLDL cholesterol, mmol/L	2.57 ± 0.40	2.19 ± 0.38	0.91 ± 0.19	.0008
LDL cholesterol, mmol/L	3.39 ± 0.42	3.40 ± 0.35	2.89 ± 0.21	.07
HDL cholesterol, mmol/L	0.76 ± 0.05	0.76 ± 0.04	1.02 ± 0.06	.0001
Total cholesterol/HDL cholesterol	9.22 ± 0.61	8.58 ± 0.55	4.83 ± 0.35	.0001

*VLDL indicates very-low-density lipoprotein; LDL, low-density lipoprotein; and HDL, high-density lipoprotein. Values are mean ± SEM. To convert values from millimoles per liter to milligrams per deciliter, multiply the cholesterol values by 38.67 and the triglyceride values by 88.574.

†Comparison between the control and nicotinic acid periods by a two-tailed paired t test.

was gradually increased from 50 mg three times daily on the first day to 1.5 g three times per day by the end of third week. Thereafter, patients continued to take the full dosage for the next 5 weeks. Patients reported as outpatients at two weekly intervals for a chemistry profile. On day 51 of each period, the patients entered the metabolic ward for 5 days, and blood samples were obtained each day as described above. On the last day of each period, plasma specimens were obtained every 2 hours for the determination of glucose levels. The patients were also interviewed about the side effects of the medication, such as flushing, rash, gastrointestinal distress, allergic reactions, and gout.

Biochemical Analyses

Fasting plasma samples were analyzed for total cholesterol, triglyceride, and lipoprotein cholesterol concentrations according to Lipid Research Clinic procedures,⁷ except that cholesterol and triglyceride concentrations were measured enzymatically.⁸ Briefly, very-low-density lipoprotein (VLDL, density <1.006 kg/L) was removed by preparative ultracentrifugation, and the cholesterol level was measured in the VLDL subtraction and the infranatant. The high-density lipoprotein (HDL) cholesterol level was measured in the supernatant after lipoproteins containing apolipoprotein B were precipitated by heparin-manganese.⁹ Cholesterol in the low-density lipoprotein (LDL) fraction was taken as the difference between the cholesterol content of the 1.006-kg/L infranatant and HDL cholesterol.

The plasma glucose concentration was determined by glucose oxidase method using a glucose analyzer (Beckman Instruments Inc, Fullerton, Calif). Quantitative analysis of glycosylated hemoglobin was done by agar gel electrophoresis using kits (Helena Laboratories, Beaumont, Tex). The plasma C-peptide concentration was measured by

radioimmunoassay kits (Mallinckrodt Inc, St Louis, Mo).

Statistical Analyses

A repeated-measures analysis of variance test was performed to compare the baseline, nicotinic acid, and control periods, to assess the effect of the sequence in which the patients were assigned to the control or active drug period, and to assess differences in response between patients receiving insulin and other therapy.^{10,11} Multiple comparisons were made with use of the two-tailed paired t test with Bonferroni's correction. When three periods were included in the analysis, $P < .0167$ was considered significant. The Wilcoxon signed rank test was used for data not consistent with the hypothesis of normality. The areas under the curve were compared with use of a t test. All results are expressed as mean ± SEM.

RESULTS

The analysis of variance did not reveal any differences in the response to nicotinic acid therapy whether patients received insulin, glyburide, or no hypoglycemic drugs; therefore, plasma lipid and lipoprotein values in all patients were pooled. Results for each patient are shown in Fig 1, and results for all patients are summarized in Table 1. The order in which patients were allocated to the drug and control periods had no effect on the results. Plasma lipid and lipoprotein concentrations were not significantly different in the baseline and control periods (Table 1).

Compared with the control period, nicotinic acid therapy reduced the plasma total cholesterol level by 24%. Plasma triglyceride levels were reduced by 45% ($P < .001$) and VLDL cholesterol levels by 58% ($P < .001$). The LDL cholesterol levels showed a modest 15% decrease with nicotinic acid therapy, which approached statistical significance ($P = .07$). The HDL cholesterol concentrations rose consistently, with

Table 2.—Me

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Insulin dosage
Glyburide dose
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Table 2.—Metabolic Variables During the Study*

	P†	Study Period		
		Baseline	Control	Nicotinic Acid
Mean plasma glucose, mmol/L‡	.0001	7.19 ± 0.31	7.85 ± 0.50	9.09 ± 0.63
24-h plasma glucose profile, mmol/L§	.0008	...	194.1 ± 6.2	213.5 ± 7.4
Insulin dosage (n = 8), U/d	.0009	85.4 ± 9.5	87.4 ± 10.0	91.5 ± 10.2
Glyburide dosage (n = 4), mg/d	.07	6.25 ± 3.0	2.50 ± 1.0	6.25 ± 3.0
Glycosylated hemoglobin, %	.0001	9.8 ± 0.4	8.7 ± 0.6	10.5 ± 0.5
24-h urinary glucose, g/d	.0001	3.1 ± 1.3	3.6 ± 1.4	14.9 ± 6.3
Plasma uric acid, μmol/L	.0001	398 ± 22	382 ± 22	511 ± 33
Body weight, kg	.0001	91.7 ± 3.3	92.1 ± 2.8	91.1 ± 2.8

*Values are mean ± SEM.

†Comparison between the control and nicotinic acid periods by a two-tailed paired t test.

‡Plasma glucose values were determined at 3, 7, and 11 AM and 4 and 9 PM for 5 days during hospitalization. To convert values from millimoles per liter to milligrams per deciliter, multiply by 18.02.

§Plasma glucose values were determined at 2-hour intervals for 24 hours on the last day of hospitalization in nine patients. Values are given in area-under-the-curve units.

||To convert plasma uric acid values from micromoles per liter to milligrams per deciliter, multiply by 0.0168.

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control period, duced the plas- l by 24%. Plas- e reduced by DL cholesterol. The LDL cho- modest 15% de- acid therapy, stistical signif- DL cholesterol nsistently, with

an average increase of 34% ($P < .0001$). The ratio of total cholesterol to HDL cholesterol also improved strikingly during nicotinic acid therapy.

The daily requirements of hypoglycemic drugs did not change in 10 of 18 patients. In one patient, due to mild hypoglycemic episodes in the control period, the daily insulin dosage was reduced by 4 U. In another patient, glyburide therapy was discontinued due to persistently low blood glucose levels reported on self-monitoring during the control period. In the third patient, nicotinic acid therapy caused an unanticipated marked deterioration in fasting plasma glucose values (from an average of 8.2 mmol/L during the control period to 18.2 and 21.5 mmol/L during the outpatient follow-up with nicotinic acid therapy), necessitating an increase in the daily insulin dosage from 76 to 105 U. Despite a 38% increase in the daily insulin dosage, the patient's mean plasma glucose values during hospitalization remained elevated (11.3 mmol/L) during nicotinic acid therapy compared with values during the control period (7.8 mmol/L). Although the increase in insulin dosage in this patient did not follow the original protocol, he was not excluded from analysis.

Overall, glycemic control deteriorated during nicotinic acid therapy, as evidenced by a 16% increase in mean plasma glucose levels, from 7.8 to 9.1 mmol/L. Concentrations of glycosylated hemoglobin increased by 21% during nicotinic acid therapy, and marked glycosuria was noted in some patients (Table 2 and Fig 2). A daylong profile of plasma glucose, obtained on the last day of each period in nine patients, also revealed significantly higher values during nicotinic acid therapy (Table 2).

Nicotinic acid therapy increased plasma uric acid levels in all the patients

(Table 2 and Fig 2). No patient, however, suffered from acute gouty arthritis. In two patients, mean plasma uric acid values rose to extremely high levels—684 and 761 μmol/L—with nicotinic acid therapy (Fig 2). Both of these patients had borderline low values of creatinine clearance, 1.05 and 1.08 mL/s, respectively, at entry into the study. A slight increase in the plasma creatinine concentration and a reduction in creatinine clearance was also noted in both patients during nicotinic acid therapy. No changes in the plasma creatinine concentration or creatinine clearance were noted in any other patients.

Most patients tolerated nicotinic acid therapy well except for minor complaints of flushing. None developed significant abnormalities in hepatic function test results throughout the study. One patient reported headaches but also noted improvement in claudication distance during nicotinic acid therapy. No patient dropped out as a consequence of side effects.

COMMENT

Soon after the discovery of the plasma lipid-lowering potential of nicotinic acid therapy by Altschul et al,¹² deterioration of glucose tolerance with this agent was reported in both nondiabetic subjects¹³⁻¹⁵ and patients with NIDDM.^{12,17} Since most of these claims were anecdotal, the potential clinical significance of this side effect has not been given due consideration. For instance, recent guidelines of the National Cholesterol Education Program can be taken to indicate that nicotinic acid is the drug of choice for treatment of dyslipidemia associated with NIDDM.¹⁸ The current investigation, therefore, was carried out to examine carefully whether nicotinic acid will favorably modify plasma lipid and lipoprotein concentrations in pa-

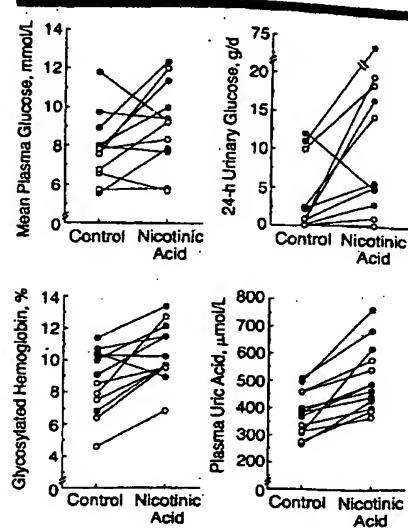


Fig 2.—Mean plasma glucose, 24-hour urinary glucose, glycosylated hemoglobin, and plasma uric acid levels during the control and the nicotinic acid periods in 13 patients with non-insulin-dependent diabetes mellitus with dyslipidemia. Solid circles indicate mean values in patients receiving insulin therapy; open circles, values in patients receiving glyburide therapy or diet alone.

tients with NIDDM without significantly worsening their glycemic control.

In our patients, nicotinic acid therapy was highly effective for lowering levels of plasma triglycerides and VLDL cholesterol. It also raised levels of HDL cholesterol, with an increase averaging 34%. Total cholesterol levels were reduced significantly, as were total/HDL cholesterol ratios. Nicotinic acid therapy reduced LDL cholesterol levels in most but not all patients. Still, it generally did not produce the rise in LDL cholesterol concentrations commonly observed with other triglyceride-lowering therapies, eg, fibrates^{14,15} or n-3 polyunsaturated fatty acids.^{16,17}

This study leaves little doubt that nicotinic acid therapy improves the lipoprotein profile in patients with NIDDM. On the other hand, the drug also causes a deterioration in glycemic control. In almost all patients, levels of glycosylated hemoglobin rose with nicotinic acid therapy. The daily profile of plasma glucose during hospitalization revealed an overall 16% elevation in mean plasma glucose levels during the nicotinic acid period. Finally, treatment with nicotinic acid induced marked glycosuria in some patients. Two-hour profiles of plasma glucose on the last day of hospitalization also revealed elevated plasma glucose values during nicotinic acid therapy.

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acid therapy. Therefore, it can be argued that the benefits of improving lipoprotein values during administration of nicotinic acid to patients with NIDDM may be counterbalanced by worsening hyperglycemia.

The results of our study suggest that a number of patients whose hyperglycemia is well controlled by dietary therapy alone may need to take hypoglycemic agents during nicotinic acid treatment. In others, the dosage of insulin or oral hypoglycemic drugs may have to be increased to control nicotinic acid-induced hyperglycemia. There are theoretical objections to increasing the insulin dosage for correction of metabolic derangements caused by another agent. For example, marked hyperinsulinemia may have a direct role in atherosclerosis.²³ Furthermore, modest increases in insulin dosage may not be able to correct nicotinic acid-induced hyperglycemia, as was observed in one of the patients. Thus, it cannot be assumed that the worsening of hyperglycemia with nicotinic acid can be easily corrected by increasing the dosage of insulin or oral hypoglycemic drugs. Since the hyperglycemic action of nicotinic acid may be dose-dependent, some may argue that the dosage of nicotinic acid can be reduced if glycemic control deteriorates. However, the improvement in the lipoprotein profile likewise may not be optimal.

The mechanism for the hyperglycemic action of nicotinic acid in patients with NIDDM is not clear. Recently, it has been reported that nicotinic acid therapy may induce insulin resistance in normal, healthy volunteers.²⁴ The same could be true for patients with NIDDM. Whether nicotinic acid has any adverse effects on beta-cell function is not known, but there is no evidence to support such an action.^{15,22} Another possibility is that, by interfering with triglyceride synthesis in the liver, nicotinic acid may enhance utilization of fatty acids at the expense of glucose; if so, this could lead to enhanced hepatic glucose output, another potential cause of hyperglycemia.

Another adverse effect of nicotinic acid therapy in this study was a consistent increase in plasma uric acid levels. Long-term therapy with nicotinic acid is known to increase the occurrence of acute gouty arthritis and to require greater usage of antigout medication.²⁴ Since patients with impaired glucose tolerance and NIDDM may be predisposed to develop hyperuricemia and gout,^{25,26} nicotinic acid therapy may further increase the risk for development of gout. Although not all investigators agree that asymptomatic hyperurice-

mia is nephrotoxic, increases in plasma uric acid levels may not be benign in patients with NIDDM who are predisposed to diabetic nephropathy. Indeed, in two of our patients, marked hyperuricemia caused by nicotinic acid therapy further compromised their renal function.

To summarize, nicotinic acid therapy markedly improves the lipoprotein profile of patients with NIDDM. Although nicotinic acid generally was well tolerated in the current patients, it is known to have a variety of side effects that preclude its use in many patients. For patients with NIDDM in particular, two side effects emerge as especially worrisome. First, the drug causes deterioration of glucose control, which, for long-term therapy, must be considered a definite drawback. Also, nicotinic acid raises uric acid levels, which increases the risk for gout and could have a negative effect on renal function. For most patients with NIDDM who have dyslipidemia, therefore, nicotinic acid therapy must be used with caution, although it may be useful in primary forms of dyslipidemia. On the basis of our previous studies, we suggest that a hydroxymethylglutaryl coenzyme A reductase inhibitor²⁷ or, for marked hypertriglyceridemia, a fibrin acid derivative²⁸ may be preferable as a lipid-lowering drug. Further studies, however, are needed to identify the optimal pharmacologic approach to lipid lowering in patients with NIDDM.²⁹

This study was supported in part by the Veterans Administration, by grant HL-23252 from the National Institutes of Health, by the Southwestern Medical Foundation, and by the Moss Heart Foundation of Dallas, Tex.

We thank Raymond Wheatley, MS, Laura Caldwell, Virginia Harris, Marjorie Whelan, RN, and the nursing and dietetic services of the metabolic ward of the Veterans Administration Medical Center, Dallas, for excellent technical support, and Beverley V. Adams, MS, for statistical analysis using the CLINFO program.

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